MONTGOMERY COUNTY OFFICE OF EMS
Medical Advisory Committee MINUTES
Meeting Date: May 25, 2016
Start: 9:30a.m. End: 11:30 a.m. estimate
Location: Public Safety Training Campus
1175 Conshohocken Rd.
Plymouth Meeting Pa.
Room: 205
RSVP: Call 610-631-6521 OR E-MAIL emartin@montcopa.org

Call to Order

- Review and approval of the February Minutes
    - Minutes reviewed and **approved, Motion: Dr. Gualiteri, Second: Kevin Bennett**
- **Executive Session (if needed)**

Guests:

- Closest EMS Unit Response-Director Tom Sullivan
    - A municipality has requested a pilot to test closest EMS unit be dispatched for priority one calls
    - In the past, the Montgomery County 911 center has experienced some minor technical issue with this procedure. These issues were resolved. Next steps are the logistical requirements, currently being evaluated.
    - Director Sullivan queried the MAC: "Does it make a difference medically if an ambulance arrives a few minutes earlier?"
    - The pilot will take place in Upper Dublin.
    - This topic has come up numerous times in the past for discussion. This is the first time a municipality has officially requested EMS respond in this fashion.
    - The pilot will be carried out be by Ambler Community Ambulance and SARS.
    - 3% of calls in Upper Dublin were priority one in 2015.
    - The physicians requested some measurable outcome, the group agreed and MCECOM will establish markers to measure
    - MECOM will initiate a Pre-Alert for Priority one calls, in an effort to make responders more aware
    - This may affect EMS agencies that surround and drive near or through Upper Dublin
    - Dr. Pulley raised the question: In a Class 1 event, a municipality's police department will respond and initiate basic care. Rarely police request EMS to expedite. More rural areas may benefit from a closet unit dispatch
    - Director Sullivan advised that this program is also being evaluated for fire responses.
    - Currently Montgomery County EMS units have an approximate 7 min. ETA to scene.
    - Dave Brown reported 1,600 calls in Upper Dublin.
    - Dave Brown reported the 3% of 2015 call volume accounts for approximately 2 calls a month.
    - The MAC felt that 48 cases a year may not be enough to make a medical decision. This may have to be spread out over a number of years in order to make an informed decision.
    - Tom Trojansky, offered caution about a county wide program. He has spoken to the municipalities that Plymouth Ambulance serves. Seven of them are not interested in the alternate response, the municipality is content with the current dispatch procedure.
    - Tom also raised concerns about the private EMS agencies being dispatched along with primary

EMS agencies. The group was reminded that this would only affect those EMS agencies that are currently on the MCECOM AVL system. The private ems agencies do not have access to this technology.

- **Dr. Usatch Summary: The MAC agrees for the pilot to move forward, collect and analyze the data. There is no support at this time to make this a county wide initiative.**

Medical Director Report

- State MAC Meeting Update-Dr. Usatch

I. Department of Health (Dr. Kupas)

1. In 2017 we will release the next update of the statewide EMS protocols. The process assumes that recommendations will be gathered during the spring and early summer and then prepared for review for the MAC by the end of summer. The goal is to have the updated protocols ready for release in January or March 2017.

2. PEHSC has been tasked by Director Gibbons to develop an educational program for glucometer use by EMTs. This program will be available on the LMS and for medical director presentation.

3. A draft EMS Information Bulletin to clarify transport of chest tubes has been developed and is included on today's agenda for review.

    a. CCT

        i. Actively draining chest tube

        ii. Closed system requiring suction

    b. ALS

        i. Vented system not at risk of occlusion or tension-pneumothorax conversion

            1. Placed acutely

            2. Underwater seal

    c. BLS

        i. Any device going to home

        ii. Bulb surgical drain

4. An EMS Information bulletin is being developed to reinforce the principles of the spinal care protocol. This protocol; will also be reviewed in the coming update to determine if additional areas of clarification are needed.

    a. Discussion ensued on some patients that are coming into the ER's that should have had a collar place pre-hospital. One concern is patients that are altered or intoxicated that are not having collars applied.

    b. Dr. Overberger asked if there have been any reports of significant injuries as a result of protocol violations. Apparently, some physicians still do not full understand the protocol.

5. II. EMS for Children Project

    a. The national EMSC project, administered by HRSA, is in the process of revising project performance measures. Future measures will include provider skill evaluation vs. recommended equipment lists.

    b. There continues to be national conversation on safe pediatric transport protocols, especially neonates from field deliveries.

6. III. PEHSC

    a. Due to DOH budget cuts, the council has been forced to institute numerous cost savings. This includes the loss of the administrative assistant. Program staff is now responsible for their own meeting planning and logistical support.

7. Representative Marty Causer has introduced legislation to increase the surcharge on moving violations as a way to increase EMSOF $$.

8. There is pending legislation to increase the availability of fireworks to consumers; the bill includes $$ to EMS and fire from an associated tax. Both EMS and fire have taken a position to not support the bill due to the consequences of fireworks.

9. There is a piece of legislation (Sen. Schwank and Costa) to eliminate what's been termed "surprise balance billing."(out of network balance billing) While it's unclear at this point if the legislation will include EMS, similar legislation in other states has mentioned prehospital services. If the intent was to include EMS and the bill would become law, it would have a negative financial impact on EMS.

10. Dr. Dan Bledsoe recently testified before the House Veterans Affairs and Emergency Preparedness Committee in support of community paramedicine.

11. Planning for the 2016 State EMS conference continues. This year the state EMS awards are coming

back to the conference as well as the opportunity for poster presentations.

OLD BUSINESS

I. Ketamine

VTR #0316-01 recommending the addition of ketamine to the state drug list. This was approved by the PEHSC board and forwarded to the Department of Health.

Dr. Alvin Wang, on behalf of the Montgomery County EMS Office, provided an overview of the ketamine pilot's final analysis. The project enrolled 26 patients exhibiting signs and symptoms of excited delirium. Dr. Wang reported that overall the pilot was very successful with no reported adverse events or outcome. Of the 26 patients enrolled, 23 achieved sedation within a few minutes following administration (4mg/kg IM or 2mg/kg IV) of ketamine.

The committee discussed how ketamine should be incorporated into the upcoming protocol update and how provider education should be addressed.

- The current ALS protocol for agitated delirium should be amended to include ketamine as an optional medication at the dosages/routes used in the pilot.

- A standardized provider education program for the LMS or live presentation by the medical director will be developed. The members noted the need for education centered on differentiating excited delirium vs. agitation. The education used in the pilot program should be incorporated into this presentation.

- There should be regional involvement in review/approval of agency utilization of Ketamine. The process would be similar to that used for etomidate. The expectation is that exclusion of an agency from this program would be because based on MAC review and not because the region decided not to participate in the initiative. An agency denied participation in the program would have the right to appeal the action to the Bureau of EMS.

- During the protocol update process, the use of ketamine maybe evaluated for other potential appropriate uses, e.g. pain control, drug-facilitate airway control, etc.

II. EMT Blood Glucose Testing

PEHSC is in receipt of a letter from Director Gibbons regarding the MAC's previous VTR permitting EMTs to perform prehospital blood glucose testing. In his letter Director Gibbons indicated the Department's acceptance of this recommendation and tasked PEHSC, through the MAC, to prepare a provider educational program for the LMS and/or live presentation by the agency medical directors.

The committee was solicited for volunteers to prepare the educational program – interested persons should

contact Butch Potter at the council office.

Following the meeting, Butch was contacted by Dr. Siberski, who volunteered to create the program with the support of the staff at the Reading Hospital College of Health Sciences.

The committee reviewed the draft memo and had no additional recommendations or changes.

IIII. Oral Glucose

The committee discussed the need to continue requiring ambulances to carry a pharmacy grade oral glucose preparation as opposed to permitting the use of food grade preparations, e.g. cake icing. The current AHA guidelines provide information regarding the use of food grade glucose that suggests it is equally effective as the more expensive prehospital designed product.

MOTION: By Dr. Neal and seconded by Dr. Siberski to recommend ambulances be permitted to carry food grade glucose or sucrose as a substitute to pharmacy grade oral glucose as it relates to the required equipment and supplies list and statewide treatment protocols.

NEW BUSINESS

I. Additional Education Requirements for PHRNs on Air and CCT Ambulances

The statewide air medical task force was asked to develop a pathway(s) for PHRNs working on air or CCT ambulances, without a critical care paramedic, to comply with PA EMS regulations requiring specific air or CCT education for at least on crew member. In some agencies this is not an issue due to the use of expanded scope paramedics, a/k/a critical care paramedics, as this information is integral to their training. However, when a PHRN is working with either an ALS paramedic or another PHRN, the nurse is required to have completed additional department approved education in air or critical care transport.

The task force developed several compliance options for our PHRNs that recognize their professional experience and national specialty certifications in emergency and critical care level nursing. The task force is bringing this issue and the proposed solution to the MAC for review and comment. Following the presentation there was additional recommendations from the committee.

II. Special Operations Workgroup Presentations

The PEHSC MAC's special operations workgroup was charged with developing recommendations to establish both the **tactical paramedic and wilderness EMT**. Today, following several months of work, the group is presenting its preliminary recommendations for committee review and comment. This is a similar path that was followed during development of the critical care paramedic and found to be beneficial during the final development phase of the project.

Drs. Siberski, Neubert and Schwartz presented the tactical paramedic project, while Drs. Neal and Conover, along with Don Scelza, presented the wilderness EMT project. Each project defined a proposed expanded

scope of practice, medication list, along with educational objectives each provider would be required to complete. In each case the proposed scope and medication list is delineated into “mission essential” and “mission optional,” which recognizes that operations in different parts of the commonwealth may require varied skill set.

The workgroup will continue developing these projects and provide best practice recommendations in areas such as agency medical director qualification.

III. Stroke Protocol Revision

Dr. Dumin presented questions and concerns regarding the current statewide ALS stroke protocol. Specifically, Dr. Dumin noted the current algorithm seems to direct the EMS provider away from stroke evaluation and care if the patient has either an altered level of consciousness or has experience seizure activity. Dr. Dunmin suggested that his facility has seen several cases where patients have experienced a stroke in addition to the above referenced concomitant conditions. He recommended the protocol’s algorithm be changed to recognize that stroke patients can also experience ALOC and/or seizures.

Dr. Reihart provided two (2) articles on stroke evaluation tools that may be more sensitive for patients with stroke symptoms resulting from large vessel occlusion. He recommended that as the committee reviews the stroke protocol for possible update, the enhanced evaluation tools be part of the conversation.

Another member discussed the current 3-hour window following onset of symptoms to the new 4.5- hour window or longer as it relates to transport to a primary vs. comprehensive stroke center. The current protocol looks at both centers equally for the purposes of field triage.

Dr. Kupas commented that he is open to exploring all issues as part of the protocol update process.

IV. Annual DOH EMS Document Update

In addition to the bi-annual protocol update, the EMS regulations require periodic publication of various EMS related documents, including but not limited to, scope of practice, medication list and equipment/supplies list. A summary sheet of the currently known updates for these documents has been provided in today’s meeting materials. The MAC will work with the BEMS to provide recommendations on the various documents.

In particular, hydroxocobalamin has gained prominence in the 2015 AHA guidelines for treatment of cyanide exposure. This medication has been discussed by MAC on several past occasions vs. the current treatment using sodium thiosulfate.

MOTION: By Dr. Reihart and seconded by Dr. Neal that hydroxocobalamin be added as an option to the approved EMS medication list for treatment of cyanide exposure and the applicable statewide protocol be amended accordingly. Motion carried.

V. New Naloxone Nasal Product

At the March PEHSC board meeting it was brought up by a member that a new nasal naloxone product is now available (Narcan Nasal Spray from Adapt Pharma). The product is a 4 mg spray that is packaged in single-use device that does not require any assembly in contrast to the combining a 2mg prefilled syringe of naloxone with an atomizing device. In some cases, the price point for this product might be cheaper than some agencies are currently paying for the drug + atomizing device.

This product is immediately available to the general public and public safety personnel who fall outside the jurisdiction of the Pennsylvania EMS Act; however, the current statewide protocol limits EMS providers to administrating 2 mgs by intranasal route. The board member requested the MAC discuss the possibility of recommending the current statewide BLS protocol (#831) be amended to include a range for intranasal naloxone administration of 2 -4 mgs.

Several members expressed support for the change, citing it will give agencies and their medical directors flexibility in product selection. Another member reminded the group that the goal of naloxone administration to be correct opioid induced respiratory depression and, if possible, to avoid recovering the patient to a state of consciousness due to the possibility of combative behavior that may endanger crew safety.

MOTION: By Dr. Reihart and seconded by Dr. Neal, to recommend statewide BLS protocol #831 be amended to include a range for intranasal naloxone administration of 2 -4 mgs.

QA Coordinator Report

- Peer Review & Quality Assurance Committee Update: Ed Martin Jr.
- CARES Data Update-Ed Martin Jr.
    - Total Out of Hospital Cardiac Arrests- 536
    - Bystander witnessed-216(40.3)
    - 911 Responder witnessed-63(11.8)
    - Bystander CPR-244(45.5)
    - F/R-129(24.1)
    - ROSC Yes-150(28.0)
    - ROSC No-386(72.0)
    - Field Termination-95(17.7)
    - Pronounced in ED-28(5.2)
    - Survival to Admin-140(26.1)
    - Survival to D/C-44(8.2)
    - Survival w/ good cerebral profusion-36(6.7)
    - Out of hosp CA Cardiac Etiology-447
    - ROSC Yes-124(27.7)
    - ROSC No-323(72.3)
    - Survival to Admin-109(24.4)
    - Survival to D/C-37(8.3)

- D/C with cerebral perfusion-29(6.5)
- Kevin Bennette inquired if the decrease in ROSC was attributed to the increases in opiate overdoses.
  - CARES is currently not measuring that data
- Dr. Jaslow is stepping down as a member of the MAC and is also resigning as Medical Director of Bryn Athyn Ambulance. The Montgomery County MAC thanks him for his years of dedication to EMS in Montgomery County and wishes him all the best as the Director of Lower Bucks Hospital

Committee Reports

- Etomidate-Dr. Neubert
  - No administrations
- Preceptor Applications-Gina Bradley
  - Four applications: Jeff Karll, Patrick Glynn, Michael Green, Michael Ford
  - **Motion: Joe Canale, Second: Dr. Pulley All four preceptors were approved**
- Helicopter-Tim Dunigan
  - YTD 50 Flights, up 14 from this time last year
  - Tim updated the flight report to include: Municipalities, Agency, Nature of flight, hour of day, class, scene or medical command authorized flights
- Montgomery County Emergency Communications-Ed Martin Jr.
  - Nature codes
    - Maryann Longo and Ed Martin identified the nature codes that can be combined to reduce the number listed.
  - CQI Update
  - EMD Ed Martin Jr.
    - Met with a select group of DISP, call takers, trainers and supervisors
    - Reviewed software based EMD programs
    - Reviewed the current EMD card system and were given some feedback on some of the issues the call takers have with the cards, such as not being easy to use.
    - Dr. Pulley suggested that a software based system would be more efficient
  - Dispatcher assisted aspirin Per Dr. Wang
    - Nobody has done a study to show patient mortality benefit yet from dispatcher ASA vs paramedic ASA. It would be an expensive study to do on a prospective basis.
    - However, aspirin levels peak in 1 hour after administration and antiplatelet effect is noted shortly after that, so it stands to reason that the sooner an aspirin is administered, the better.
    - Based on the literature that:
      - 1) aspirin levels peak quickly after administration
      - 2) dispatchers are successfully able to navigate a protocol regarding the appropriateness of aspirin 3
      - 3)despite our best efforts, opportunities for paramedic aspirin administration are sometimes missed
  - **From Dr. Wang: instructions on aspirin administration from dispatchers are a reasonable treatment option for suspected cardiac chest pain. it will take some fine tuning to work**

out an exact protocol (indication, age group, contraindications, etc)

- Discussion: Ed advised that we are behind in the nation and neighboring counties
- Dr. Pulley some concerns with patients c/o back & abdominal pain possible Abdominal Aortic Aneurysm.
- Donny Miller requested that EMS be advised when a patient has taken an ASA
- Dr. Overberger had some concerns whether the patient took the right ASA prior to EMS arrival: can medics give 4 more baby chewable ASA once on scene
- **Motion to approve: Joe Canale, Seconded: Dr. Minzak**

Old Business

- Naloxone Program-Ed Martin Jr.
  - New dispensing devices
    - See Above
- Community Paramedicine update-Brian Pasquale
  - No update
- I-Gel Airway device-Anthony McGrail
  - 97% success rate, pilot continues
- EMS Training Institute Updates-Brian Pasquale
  - Gina Bradley update, paramedic is on schedule to begin July 6, seats still open in the upcoming EMT classes, seats still open for EMT instructor methodology
- Local transport service shortages
  - AMR has entered into the market and has signed agreements with some local hospital systems

New Business

- House Bill 328 Blood Draw by paramedics
  - Bill is in infancy at state senate.
  - MAC Recommends that EMS agency enter into an agreement with local Police Department.
  - Dr. Usatch does not advocate paramedics perform legal blood draws at the scene of an MVC.

- Hospital Access to Emergency Transport
  - Hospital dialing 911 for emergent transports.
  - Ed facilitated a scenario: Chest pain, c STEMI, ER physician wants the ability to call 911
  - Joe Canale asked if transfer violated EMTALA.
    - Dr. Usatch advised not EMTALA violation.
  - Tom Trojansky-308 has an agreement with local hospital but billing could be an issue, his recommendation 911 service should have an agreement in place with the hospital.
  - 911 services cannot refuse to go to a hospital.
  - Kevin Thomas presented a plan for EMS and local hospital: A=Private Service B=Second Private service C=then call 911.
  - If a hospital in Montgomery County calls 911, the call should be evaluated immediately to identify if that was the best method.
- Physician Directed Response to hospital
  - Can a non-medical command physician mandate an ambulance to respond lights & sirens to the hospital for the purposes to transport a patient for an inter-facility transport
  - Tim advised that the BEMS doesn't advocate for these types of responses
  - Kevin Thomas: this is a physician to physician response

- Tim advised on two recent incidents
    - First incident: ER Medical Command Physician ordered, private service gave a 20min ETA
    - Second Incident, private service gave a 45 min ETA, but never made it due to being involved in a MVA
- Dr. Overberger advocated that physician should not give specific directions

- W-18
    - See Attached

Other new business from the floor

- Hospital Destination
    - Ed Martin reported on: Recent increase in complaints of EMS agencies not transporting patients to hospital of choice. Highly recommend EMS agency med command physician work with operations to develop a policy and have a copy of policy in each unit

2016 MAC Meetings Schedule

August 31, 2016, November 30, 2016

Montgomery County Emergency Medical Services Council Meetings

June 1, 2016

Adjourn

Motion: Dr. Pulley
Second: Joe Canale